

Name _____
Last First

CDCR No. _____

FOTEP Initial Screening

Revised 2-07

Interview Date ____/____/____

Interviewer Name _____

SAP INFORMATION

SAP Name _____ SAP Code _____

SAP Contact _____ Phone (____) ____ - ____ Parole Region _____

FEMALE PARTICIPANT INFORMATION

Name: _____ SSN _____ CDCR No. _____

DOB ____/____/____ EPRD ____/____/____ MAX Date ____/____/____

County of Last Legal Residence (CLLR) _____

Drivers License/ID No. _____ Exp Date ____/____/____

Social Security Card ☐ Yes ☐ No Sexual Identity _____

Birth Certificate ☐ Yes ☐ No Place of Birth _____

PERSONAL INFORMATION

Ethnicity _____ Religious Beliefs _____

Primary Language _____ Secondary Language _____

Affiliations _____

Name _____
Last First

CDCR No. _____

Educational Background

What is the highest grade you have completed? Please circle below

Elementary						Junior High			High School			College			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Diploma <input type="checkbox"/> Yes <input type="checkbox"/> No						GED <input type="checkbox"/> Yes <input type="checkbox"/> No			Enrolled <input type="checkbox"/> Yes <input type="checkbox"/> No						

Employment History and Vocational Information

Please tell us about your most recent employment history _____

Have you ever had any employment related training such as, Special Trades, Vocational Trainings?

☐ Yes ☐ No If yes, which trade or trainings? _____

What type of vocational/educational training would be most interesting to you? _____

What are your career goals? _____

What job skills do you have? _____

What are some of the strengths that you bring to a job? _____

What are some of the supports that you require to achieve your goals? _____

Name _____
Last First

CDCR No. _____

Medical and Mental Health Information

Are you currently on any medications? ☐ Yes ☐ No If yes please list

Have you ever been hospitalized for medical problems or injuries? ☐ Yes ☐ No If yes please explain

Do you have any pending medical procedures? ☐ Yes ☐ No If yes please explain

Do you have any disabilities, chronic illness, or medical conditions? ☐ Yes ☐ No

If yes please explain

Are you pregnant? ☐ Yes ☐ No

Have you ever been classified CCCMS and/or EOP? ☐ Yes ☐ No

Have you ever taken psychotropic medication? ☐ Yes ☐ No if yes please explain

Are you Currently classified CCCMS (with or without medication) ☐ Yes ☐ No

Sup Transmittal Coversheet 160 days prior to release, Civil Addicts 109 days prior to release.

Name _____
Last First

CDCR No. _____

Criminal History

Parole Date ____/____/____ - Parole Region _____ Parole Unit _____

Age of first arrest? ____ Is this your first prison term? ☐ Yes ☐ No If no, how many terms _____

If no, please list all prior convictions in the table below.

COUNTY				STATE			
Year	Location	Offense	Time Served	Year	Location	Offense	Time Served

What was your relationship with your co-defendants in most current offense listed above? _____

Explain any arrests you have had involving harm or neglect to a child _____

Are you gang affiliated (involvement/member) ☐ Yes ☐ No If yes, which one _____

What was that experience like for you? _____

SAP Transitional Counselor 150 day prior to release. Civil Adds 150 days prior to release.

CDCR No. _____

Do you have any legal matters pending? (including child support, traffic fines, custody, holds, INS, restitution, warrants).

Have you ever been charged/convicted with arson ? ☐ Yes ☐ No Sexual crime ☐ Yes ☐ No
If yes, explain _____

Do you have any children? ☐ Yes ☐ No *If yes, please list below*

NAME	AGE
1.	
2.	
3.	
4.	
5.	
6.	

Name _____
Last First

CDCR No. _____

Child I Information

Name _____ DOB ____/____/____ Age ____
Last First

Sex ☐ Male ☐ Female Ethnicity _____

Address _____ City _____ Zip Code _____

Phone (____) ____ - ____ Father's Name _____

Current Care Giver _____ Relationship to Participant _____

Was Placement Voluntary ☐ Yes ☐ No School Status/Grade Level _____

Describe your current relationship with this child. _____

Are you interested in bringing this child to FOTEP? ☐ Yes ☐ No

How do you plan to reunite with this child? Explain in detail _____

Has child/adolescent ever been convicted of a crime? ☐ No ☐ Yes If yes, explain _____

Do you have an open CPS/DCFS case? ☐ No ☐ Yes If yes, please complete the following

Case Worker Name _____ Phone (____) ____ - ____

What is your current court order reunification plan? _____

To your knowledge, does this child have any special needs? ☐ No ☐ Yes If yes, explain _____

Has your child ever been mistreated or abused? Sexual, Physical, Mental, Neglect, Emotional _____

Has your child ever received counseling? ☐ No ☐ Yes If yes, explain _____

If yes, will you sign a release of information? ☐ No ☐ Yes

What are some of your hopes regarding reunification? _____

What are some of your fears regarding reunification? _____

SAC Transitional Carecenter 180 days prior to release. Child Admits 180 days prior to release.

Name _____
Last First

CDCR No. _____

Child II Information

Name _____ DOB ____/____/____ Age ____
Last First

Sex ☐ Male ☐ Female Ethnicity _____

Address _____ City _____ Zip Code _____

Phone (____) _____ Father's Name _____

Current Care Giver _____ Relationship to Participant _____

Was Placement Voluntary ☐ Yes ☐ No School Status/Grade Level _____

Describe your current relationship with this child. _____

Are you interested in bringing this child to FOTEP? ☐ Yes ☐ No

How do you plan to reunite with this child? Explain in detail _____

Has your child/adolescent ever been convicted of a crime? ☐ No ☐ Yes If yes, explain _____

Do you have an open CPS/DCFS case? ☐ No ☐ Yes If yes, please complete the following
Case Worker Name _____ Phone (____) _____

What is your current court order reunification plan? _____

To your knowledge, does this child have any special needs? ☐ No ☐ Yes If yes, explain _____

Has your child ever been mistreated or abused? Sexual, Physical, Mental, Neglect, Emotional _____

Has your child received counseling? ☐ No ☐ Yes If yes, explain _____

If yes, will you sign a release of information? ☐ No ☐ Yes

What are some of your hopes and fears regarding reunification? _____

SAP Treatment Counselor 180 days prior to release; Child Admits 180 days prior to release.

Name _____
Last First

CDCR No. _____

Interviewers Comments

[illegible][illegible][illegible]

[illegible]

[illegible]

[illegible][illegible][illegible][illegible]

Please provide the following narrative of the following:

1. Overview of Program Status:
2. Administrative Activities:
3. Staffing (This includes new hires/terminations/vacancies - plans for filling vacant positions)
4. Alumni Activities:
5. Issues of Concerns:

FOTEP Initial Assessment Phase II

Valid through
December 31, 2003

A biological, psychological, and social assessment of the participant. It also determines the current legal and living status of the participant and their child(ren). Administered to each female participant in the SAP that has received acceptance into the FOTEP.

Interview Date ____/____/____

Interviewer Name _____

FOTEP Name _____

Participant Information

Name _____ SSN _____ CDC No _____
Last First

DOB ____/____/____ EPRD ____/____/____ Max Date ____/____/____

County of Last Legal Residence (CLLR) _____

SAP/Parole Information

SAP Short Name _____

SAP Contact _____ Phone (____) ____-____

Agent of Record _____ Parole Unit _____ Phone (____) ____-

Substance Abuse History

At what age did you start using drugs or alcohol? _____

What were the circumstances of you starting to use drugs or alcohol? _____

What type of drug did you first start using? _____

What is your longest period of abstinence from drugs and alcohol? _____ Weeks/Months

Do you feel that your usage causes problems in your life? ☐ Yes ☐ No

☐ Please explain _____

Participant Drug Use

How much/often and when do you use alcohol, illegal drugs, prescription drugs, and non-prescription drugs?

Type of Substance	Amount	How Often	Last Used
Primary:			
Secondary:			
Tertiary:			

Family Drug Use

Do your parents or siblings use alcohol, illegal drugs, prescription or non-prescription drugs?

☐ Yes ☐ No ☐ If yes, please explain _____

Are any of these family members in recovery? ☐ Yes ☐ No

☐ If yes, please explain _____

FOTEP Community Case Manager by 150 days prior to release

Name _____ CDC No _____
Last First

Significant Other Drug Use

Does your significant other use alcohol, illegal drugs, prescription or non-prescription drugs?

☐ Yes ☐ No ☐ If yes, please explain _____

Is your significant other in recovery? ☐ Yes ☐ No

☐ If yes, please explain _____

Other Treatment Program Information

How many times have you attempted treatment? _____

Most recent treatment attempt ____/____/____ City/State _____

Approximate date of admission into program ____/____/____ Duration of Stay _____

Have you ever successfully completed treatment? ☐ Yes ☐ No How many times? _____

Your likes and dislikes about your treatment? _____

Participant Health Information

Do you have any allergies? ☐ Yes ☐ No ☐ If yes, what are you allergic to? _____

Are you currently on any medications? ☐ Yes ☐ No ☐ If yes, please list _____

Have you ever been hospitalized for medical problems or injuries? ☐ Yes ☐ No

☐ If yes, please explain _____

Do you have any disabilities, chronic illness, or medical conditions? ☐ Yes ☐ No

☐ If yes, please explain _____

What medical/dental care do you need? _____

Are you on any special diets? ☐ Yes ☐ No

☐ If yes, please explain _____

Are you pregnant? ☐ Yes ☐ No ☐ If yes, when is your due date? ____/____/____

Any history of high risk pregnancies? ☐ Yes ☐ No

☐ If yes, please explain _____

Name _____ CDC No _____
Last First

Mental Health History

Have you ever been diagnosed with any mental health issues? ☐ Yes ☐ No

☐ If yes, please give a date and explain

Date ____/____/____

Have you ever received counseling or been hospitalized for psychological issues? ☐ Yes ☐ No

☐ If yes, please give a date and describe the issues

Date ____/____/____

Have you ever been classified CCCMS? ☐ Yes ☐ No

Have you ever taken psychotropic medications? ☐ Yes ☐ No

☐ If yes, please give a date and explain

Date ____/____/____

Are you currently classified CCCMS (with or without medication)? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

☐ If yes, please identify episodes

Age	By what means	How many times	Under what circumstances

Have you ever received counseling for your suicide attempts? ☐ Yes ☐ No

☐ If yes, please give a date and explain

Date ____/____/____

Other Comments

FOTEP Community Case Manager by 150 days prior to release

Name _____ CDC No _____
Last First

Most Current Marital Status

Marital Status ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single ☐ Significant Other

Cohabited with you? ☐ Yes ☐ No Length of Relationship _____

Do you have any reunification plans with your mate? ☐ Yes ☐ No

☐ If yes, what are your plans? _____

Significant Other Information

Name _____ DOB ____/____/____ Age ____
Last First

Gender ☐ Male ☐ Female

Address _____ Phone (____) ____-____

City _____ State _____

Occupation _____

Height _____ Weight _____ Hair Color _____ Eye Color _____
ft. in. lbs.

Ethnicity _____

Identifying Marks _____

Domestic History

Number of previous marriages _____ Number of previous cohabitants _____

In all of your prior relationships, were any of these partners:

Did they abuse alcohol/drugs? ☐ Yes ☐ No ☐ If yes, what? _____

Physically abusive to you? ☐ Yes ☐ No ☐ If yes, how many? _____

Verbally/emotionally abusive to you? ☐ Yes ☐ No

Sexually abusive to you? ☐ Yes ☐ No ☐ If yes, how many? _____

Were there ever any domestic violence arrests? ☐ Yes ☐ No

☐ If yes, who? _____ When? _____

Name _____ CDC No _____
Last First

Family Issues

In your family, were there any of the following. Check all that apply.

	Mother	Father	Other Family Members	If yes, please explain
Parental Violence				
Child Battering				
Alcoholism				
Drug Addiction				
Mental Health				
Physical Abuse				
Sexual Abuse				
Prison Term				
Death				

Employment Identification

Are you looking forward to employment? ☐ Yes ☐ No

☐ If no, what are your hopes/concerns? _____

Can you read/write English?

☐ Yes ☐ No

Do you have computer skills?

☐ Yes ☐ No

☐ If yes, what kind? _____

Can you type?

☐ Yes ☐ No

☐ If yes, how many wpm? _____

Are you bilingual?

☐ Yes ☐ No

Can you read/write a second language?

☐ Yes ☐ No

Employment History

What entry-level position are you seeking? _____

Have you ever been employed?

☐ Yes ☐ No

☐ If yes, where? _____

When did you last work? _____/_____/_____

Mo Yr

What was your job title? _____

Why did your job end? _____

Do you have a resume?

☐ Yes ☐ No

☐ If yes, is it current?

☐ Yes

☐ No

Have you acquired any skills while incarcerated?

☐ Yes

☐ No

☐ If yes, please list skills _____

What settings are you prohibited from working in? _____

Name _____ CDC No _____
Last First

Volunteer Work

Have you ever done volunteer work ☐ Yes ☐ No

If yes, where? _____
What were your duties? _____
How long ago? _____

Social Security

Have you ever been on social security/state disability? ☐ Yes ☐ No
Are your benefits still accessible? ☐ Yes ☐ No

Final

What are some of your expectations of the FOTEP program for yourself and your children?

FOTEP Community Case Manager by 150 days prior to release

INDIVIDUAL TREATMENT PLAN

Problem Indexes: 1-Substance Use Issues, 2-Biomedical, 3- Behavioral/Cognitive/ Emotional, 4-Readiness to Change, 5- Relapse/Continued Use Potential, 6-Living/Recovery Environment

Person Served Name:			Phase:		WH ID#		
Date Initiated: <small>Date work started</small>	Index #:	Problem Statement: Need or problem identified in the words of the person served with evidence it is a need or problem.	Goal and Objective: Accomplishment with: Specific; Pertinent; Attainable; Measurable; Observable; Understood steps.	Approach / Strategy: Assignment, intervention, service, strategy, or task to complete objectives.	Treatment Team: Parties in this plan	Target Date: Date work is due.	Status Date: Describe Progress
		My need or problem is:	I want to:	<input type="checkbox"/> Assignment <input type="checkbox"/> Case Mgmt <input type="checkbox"/> Counseling <input type="checkbox"/> Education <input type="checkbox"/> Other (Specify):			
			Each <input type="checkbox"/> Day; <input type="checkbox"/> Week I will:				
		My need or problem is:	I want to:	<input type="checkbox"/> Assignment <input type="checkbox"/> Case Mgmt <input type="checkbox"/> Counseling <input type="checkbox"/> Education <input type="checkbox"/> Other (Specify):			
			Each <input type="checkbox"/> Day; <input type="checkbox"/> Week I will:				
		My need or problem is:	I want to:	<input type="checkbox"/> Assignment <input type="checkbox"/> Case Mgmt <input type="checkbox"/> Counseling <input type="checkbox"/> Education <input type="checkbox"/> Other (Specify):			
			Each <input type="checkbox"/> Day; <input type="checkbox"/> Week I will:				

90-Day Review Date _____

Person Served Signature _____ Date _____
 Staff Signature _____ Date _____

INDIVIDUAL TREATMENT PLAN

Person Served Name:			Phase:		WH ID#		
Initiated Date: Date work started.	Index #:	Problem Statement: Need or problem identified in the words of the person served with evidence it is a need or problem.	Goal and Objective: Accomplishment with: Specific; Pertinent; Attainable; Measurable; Observable; Understood steps.	Approach / Strategy: Assignment, intervention, service, strategy, or task to complete objectives.	Treatment Team: Parties in this plan.	Target Date: Date work is due.	Status Date: Describe Progress
		My need or problem is:	I want to:	<input type="checkbox"/> Assignment (Specify): <input type="checkbox"/> Case Mgmt <input type="checkbox"/> Counseling <input type="checkbox"/> Education <input type="checkbox"/> Other (Specify):			
			Each <input type="checkbox"/> Day; <input type="checkbox"/> Week I will:				
		My need or problem is:	I want to:	<input type="checkbox"/> Assignment (Specify): <input type="checkbox"/> Case Mgmt <input type="checkbox"/> Counseling <input type="checkbox"/> Education <input type="checkbox"/> Other (Specify):			
			Each <input type="checkbox"/> Day; <input type="checkbox"/> Week I will:				
		My need or problem is:	I want to:	<input type="checkbox"/> Assignment (Specify): <input type="checkbox"/> Case Mgmt <input type="checkbox"/> Counseling <input type="checkbox"/> Education <input type="checkbox"/> Other (Specify):			
			Each <input type="checkbox"/> Day; <input type="checkbox"/> Week I will:				

Long-Term Goals: *(specific goals that are beyond the scope of the program)*

Client Event Begin/End Log for SASCA and FOTEP

Name^R:

FirstMiddleLast

Gender^R:

Ethnicity^R:

Race^R: (Check only one)

☐ American Indian/Alaskan Native
☐ African American
☐ Asian
☐ Caucasian
☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander

Age^R:

Preferred Language^R:

Sexuality^R:

Security #^C:

Birth Date^R:

CDC ID:

C ID:

CSAS ID:

ice	Facility	Funding	Begin Date	Counselor (PRINT ONLY)	Current Date	Sup. Initials	End Date	Counselor (PRINT ONLY)	Current Date	Sup. Initials	Event End Reason

at End Reason Key: (Write the number next to the applicable event end reason in the Event End Reason column.)

changed Facility

changed Funding

Completed Program Successfully

andoned TX AMA

removed by PO or Arrested

6. Never Showed

7. Undetermined

8. Asked to Leave

9. Asked to Leave: Refusal to Program

10. Asked to Leave: Drug/Alcohol Use

11. Asked to Leave: Violence

12. Asked to Leave: Medical/Psych Reason

13. Asked to Leave: Funding Ended/Discharged From Parole

14. Transferred

15. Non-Compliance

16. DTF: Cancelled

17. DTF: Returned to Custody

18. Other Reason (specify below)

Required, fr not be submitted unless these questions are answered.

^C Recommended, it is highly recommended that these questions are answered

17.

WH SUPPLEMENTAL ADMISSION FORM

Date Information is Gathered^R: ____/____/____

Name^R: _____ WH ID^R: _____ Date of Birth^R: ____/____/____
First Middle Last

CONSENT TO FOLLOW UP: ☐ Signed ☐ Refused to sign client initials: _____

CLIENT ADDRESS

Address: _____
 City: _____
 State: _____ Zip Code: _____
 County: _____
 Phone: _____ - _____ - _____

NEXT OF KIN / EMERGENCY CONTACT

Name: _____
 Address: _____
 City: _____
 State: _____ Zip Code: _____
 Relation: _____ ☐ Newsletter
 Phone: _____ - _____ - _____

(Client initials)

GENDER

- ☐ Female
☐ Male
☐ Transgender

RACE

(check one only)

- ☐ African American
☐ Asian/Pacific
☐ Caucasian
☐ Hispanic
☐ Native American

ETHNICITY

(check one only)

- ☐ African
☐ African American
☐ American
☐ Chinese
☐ Cuban
☐ European
☐ Haitian
☐ Hawaiian
☐ Indian
☐ Inuit/Nat AL
☐ Japanese
☐ Korean
☐ Laotian
☐ Latin American
☐ Mexican
☐ Mid Eastern
☐ North African
☐ Philippine
☐ Puerto Rican
☐ South/Cent Amer
☐ Vietnamese
 Other: _____

PREFERRED LANGUAGE

(check one only)

- ☐ Asian
☐ English
☐ Indo/Chinese
☐ Mid Eastern
☐ Sign
☐ Spanish
☐ Other: _____

SEXUALITY

- ☐ Bisexual
☐ Declined to specify
☐ Gay/Lesbian
☐ Heterosexual
☐ Undecided

EMPLOYMENT

(check one only)

- ☐ FT emp & student
☐ FT student
☐ Full time emp
☐ PT emp & student
☐ Part time emp

- ☐ Unemp/disabled
☐ Unemp/no seek
☐ Unemp/seeking
☐ Volunteer

Enter how long: _____

- ☐ Days
☐ Months
☐ Years

TYPE OF EMPLOYMENT

(check only one, skip if unemployed)

- ☐ Exec/Management
☐ Farm/Forest
☐ Prod/Labor
☐ Sales/Service
☐ Technical
☐ Transportation services

INCOME SOURCE

(check one only)

- ☐ AFDC
☐ GA
☐ No Income
☐ Pension
☐ Private Disability Ins
☐ SDI
☐ SSDI
☐ SSI

- ☐ Trust fund
☐ Unemp ins
☐ Wage or salary
☐ Other: _____

- ☐ Yes Does the client
☐ No have a representative
 payee?

INCOME LEVEL

(legally earned only)

- ☐ Under 10,000
☐ 10,001-20,000
☐ 20,001-40,000
☐ 40,001-60,000
☐ 60,001-80,000
☐ 80,001-100,000
☐ Over 100,000

- ☐ Yes Is the client a
☐ No veteran of the
 US armed forces ?

FAMILY STATUS

(check one only)

- ☐ Divorced
☐ Domestic part
☐ Married
☐ Separated
☐ Single
☐ Widowed
☐ Other: _____

REFERRAL SOURCE

(check one only)

- ☐ Brochure
☐ 12 Step
☐ Case Manager
☐ Criminal justice
☐ Employer
☐ Family
☐ Friend
☐ Guardian
☐ Health dept
☐ Homeless services
☐ Maximus
☐ Medical facility
☐ Mental health
☐ OP program
☐ Resident program
☐ RPI
☐ School
☐ Self referred
☐ Social service
☐ TAP
☐ Yellow pages
☐ Other: _____

PREVIOUS PROGRAM

(check one only, skip if none)

Most recent program: _____
 Total previous programs: _____
 Entered most recent program ____/____/____
 Exited most recent program ____/____/____

PREVIOUS PROGRAM TYPE

(check one only)

- ☐ Alcohol OP
☐ Alcohol residential
☐ Detox
☐ Drug OP
☐ Drug Residential
☐ Maintenance
☐ Psychiatric hospital

SUPPLEMENTAL ADMISSION FORM - INSTRUCTIONS FOR COMPLETION

2

Form is used to document various items of information when a Client is admitted to Walden House. A Client admit begins a treatment episode. Do not use this form to record transfers between Fundings, Facilities or Modalities, or to Discharge a Client from Treatment at Walden House.

This helps enormously when reading the forms and also makes data entry faster and more accurate.

Make an entry in each and every section. Select the option which most closely matches the Client's circumstances. In categories where the 'Other' option IS available, enter a new Option as required. In categories where the 'Other' option IS NOT available, please select the option which most accurately describes the category.

INFORMATION IS GATHERED: Enter the date the information is collected.

CLIENT NAME: Enter the client's full name. Please give the first and last name.

ID#: Enter the Walden House client identification number of the client to be discharged.

BIRTH DATE: Enter the Client's date of birth.

WALDEN HOUSE FOLLOW-UP: This question goes hand in hand with the Walden House Authorization/Consent To Follow-Up form. Indicate whether or not the client has consented to participate in the Walden House Follow-Up procedures. This question cannot be completed and the client must initial their response.

CLIENT ADDRESS: Enter the Client's current mailing address at the time of Admission to this Treatment Episode. Please include the zip code. In cases where the Client is homeless, indicate 'HOMELESS' in the address line. In cases where the Client is Incarcerated, indicate 'INCARCERATED' on the Address line. In each case, please include the Zip Code, either of the section of the city in which the Client was homeless, or of the section of the city where the incarcerating institution is located. In all cases, please provide the County.

NEXT OF KIN ADDRESS: Enter the address information for the Client's next of kin, or other Emergency Contact person. Do not leave this blank please. Indicate the relationship of the Emergency Contact person to the Client and indicate if the Contact person should receive Walden House Newsletter. If the Client elects to have a Newsletter sent to this address, the Client **MUST** initial the Permission Box.

Select an option which most closely matches the Client's physical gender.

RACE: Enter the Client's own self-identification as to race. A Client may elect to identify with any classification desired. An 'Other' category has not been included here, since several of the reports generated from this information do not allow for an 'Other' category. Client's race is a racial identification that most closely suits their preference and use the 'ETHNICITY' section to elaborate.

ETHNICITY: Select the Ethnic Background with which the Client most closely identifies. Please try to select from the offered options; however the 'Other' option may be used if necessary.

PREFERRED LANGUAGE: Select the client's Preferred Language; the language the Client would prefer to speak on a day to day basis.

SEXUAL IDENTITY: Select the option which most closely matches the Client's preferred sexual identity.

EMPLOYMENT: Select the Client's Employment Status at the time of Admission. If the Client is Incarcerated, answer this section with their status at the time of Incarceration.

TYPE OF EMPLOYMENT: Select the Employment Category which best suits the Client's most recent, or current, job.

INCOME SOURCE: Select which best describes the Source of Income used to cover the Client's day-to-day expenses. Note: SSDI = 'Social Security Disability Insurance', SDI = 'State Disability Insurance'.

INCOME LEVEL: Select the income range of the Client's Gross Annual Income. Only include legally earned income!

VETERAN STATUS: Indicate if the client is a Veteran of any branch of the United States Armed Forces.

FAMILY STATUS: Select the category which best describes the Client's Family Status at the time of Admission.

REFERRAL SOURCE: Select the category which best describes the Source of the Client's referral to Walden House for this treatment episode.

PREVIOUS DRUG TREATMENT PROGRAMS: Indicate if the Client has participated in previous Drug Treatment programs, including previous Episodes at Walden House. If the Client HAS NOT participated in previous Drug Treatment programs, you may skip to the FAMILY STATUS section. If the Client HAS participated in previous treatment, provide the Name of the most recent Program, the number of days the Client participated in the program. Also, please provide the total number of Treatment Programs in which the Client has participated.

PREVIOUS PROGRAM TYPE: Select the category which best describes the Type of the Client's most recent previous Program.

How many children under the age of 18 does the client have? _____

You may skip this section if the client has no children under the age of 18 — Use form MIS-006 if client has more than 3 children

CHILDREN/DEPENDENTS	Child's first name?	Child's gender	Child's date of birth	CPS court order?	Who does the child live with? (check one only)		
Child 1 -		M F	/ /	Y N	<input type="checkbox"/> Client	<input type="checkbox"/> Relatives	<input type="checkbox"/> Friend
					<input type="checkbox"/> Foster care	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other
Child 2 -		M F	/ /	Y N	<input type="checkbox"/> Client	<input type="checkbox"/> Relatives	<input type="checkbox"/> Friend
					<input type="checkbox"/> Foster care	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other
Child 3 -		M F	/ /	Y N	<input type="checkbox"/> Client	<input type="checkbox"/> Relatives	<input type="checkbox"/> Friend
					<input type="checkbox"/> Foster care	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other

EDUCATION (check one only) 3rd grade or less 4th grade 5th grade 6th grade 7th grade 8th grade 9th grade 10th grade 11th grade 12th grade College Freshman College Sophomore College Junior College Senior Post graduate	CERTIFICATIONS (check one only) <input type="checkbox"/> GED <input type="checkbox"/> HS diploma <input type="checkbox"/> Two year deg / AA <input type="checkbox"/> Four year deg / BA / BS <input type="checkbox"/> Post grad <input type="checkbox"/> Other: _____ Date the highest educational level was completed ____/____/____	LIVING SITUATION (check one only) <input type="checkbox"/> Homeless <input type="checkbox"/> Foster care <input type="checkbox"/> Incarcerated <input type="checkbox"/> Independent <input type="checkbox"/> Mntl hlth institution <input type="checkbox"/> Parent/Guard <input type="checkbox"/> Public housing <input type="checkbox"/> Relatives <input type="checkbox"/> Share/No pay <input type="checkbox"/> Share/Pay ex <input type="checkbox"/> Spouse/Partner How long? ____ <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years	ENTERING FROM: (check one only, skip if not homeless) <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Shelter <input type="checkbox"/> Street <input type="checkbox"/> Transition housing Total number of times client has been homeless: _____ JUSTICE SYSTEM (check one only) <input type="checkbox"/> Diversion <input type="checkbox"/> Incarcerated/sentence <input type="checkbox"/> Incarc./Pending sentence <input type="checkbox"/> Incarc./Indeterminate sentence <input type="checkbox"/> Supervised Release <input type="checkbox"/> Not applicable <input type="checkbox"/> Parole <input type="checkbox"/> Pending sentence <input type="checkbox"/> Probation
---	--	--	--

You may skip this section if the client has no involvement with the justice system

JURISDICTION (check one only) ☐ Federal ☐ State ☐ City/County
TYPE OF CRIME (check one only) ☐ Drug ☐ Property ☐ Violence ☐ Prostitution ☐ Other

County of sentencing: _____
Probation/parole/diversion expiration date: ____/____/____
Total days over past year client was in jail/prison: _____
Total number of times this client has been incarcerated: _____
Length of the longest incarceration: _____ ☐ Days ☐ Months ☐ Years

PROBATION / Name: _____
PROBATION OFFICER Address: _____ City: _____
State: _____ Zip Code: _____ Phone: _____ - _____ - _____

CRIMINAL INFO Has the client ever belonged to a street gang? ☐ Yes ☐ No
Is the client currently involved in a street gang? ☐ Yes ☐ No
Which street gangs? _____
Has the client ever belonged to a prison gang? ☐ Yes ☐ No
Is the client currently involved in a prison gang? ☐ Yes ☐ No
Which prison gangs? _____

CLIENT RATINGS The client rates...
overall life satisfaction as: poor fair good excellent
physical health as: ☐ 1 ☐ 2 ☐ 3 ☐ 4
mental health as: ☐ 1 ☐ 2 ☐ 3 ☐ 4
their ability to abstain from drugs/alcohol as: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Beck Depression Inventory score _____

HEALTH CARE COVERAGE (check one only) <input type="checkbox"/> Local clinic <input type="checkbox"/> Alternative med <input type="checkbox"/> Emergency room <input type="checkbox"/> Incarcerated <input type="checkbox"/> Managed/HMO <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Other: _____	<input type="checkbox"/> Private insurance <input type="checkbox"/> Private physician <input type="checkbox"/> VA/Military	DISABILITY (check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Developmental <input type="checkbox"/> Hearing <input type="checkbox"/> Mental <input type="checkbox"/> Physical <input type="checkbox"/> Speech <input type="checkbox"/> Visual
---	--	---

REN: Indicate how many children under the age of 18 the client has, regardless of whose custody the child(ren) is in or where the child(ren) live. If the client has at least 1 child under 18, for each child under 18 provide the child's first name, gender, birthdate, whether or not the child is on CPS court and where the child(ren) live. If the client has more than 3 children under 18 use the MIS-006 form.

EDUCATION: Select the category which best describes the current level of the Client's Education.

CERTIFICATIONS: Please select the category which matches the highest diploma or other Academic Certification earned by the Client.

LIVING SITUATION: Select the category which best describes the Client's Living Situation at the time of Admission. If the Client is 'Homeless', provide length, in days, of the current Homeless episode. Also please provide the total number of times the Client has been Homeless in the past.

ORIGIN: If the Living Situation is 'Homeless', select the category which best describes the situation from which the Client will be entering the Homeless House.

CRIMINAL JUSTICE SYSTEM: Select the category which best describes the Client's status with the Criminal Justice system at the time of Admission. If the status is 'Not Applicable', you may skip to the PRIMARY DRUG section.

JURISDICTION: Indicate the Level of Jurisdiction in which has authority over the Client at the time of Admission.

TYPE OF CRIME: Select the category which most closely describes the incident leading to the Client's arrest.

Please enter the client's jail number.

Please enter the Name of the County where sentence was passed.

EXPIRATION DATE: Enter the date on which the Client's involvement with the Criminal Justice system will expire.

NUMBER OF INCARCERATIONS: Please provide an estimate of the total number of times the Client has been arrested and convicted of an offense.

NUMBER OF DAYS: Enter the total number of days, in the last year, that the client spent in jail or prison.

LONGEST SENTENCE: Please provide the length of the longest sentence ever received by the Client.

Provide the name, address, and phone number of the probation or parole officer.

INFO: Indicate whether or not the client is currently, or has been, in prison or street gangs, and which gang(s).

CLIENT RATINGS: On a scale of one to four, one being worst, four being best, specify how the client rates:

overall life satisfaction

the client's physical health

the client's mental health

the client's ability to abstain from drugs and alcohol

DEPRESSION INVENTORY SCORE: If applicable, indicate the score of the Beck Depression Inventory.

HEALTH CARE COVERAGE: Select a category which best describes the Client's primary source of Medical Services.

DISABILITY: Other than the disability of drug dependence, if the Client has any other disabilities, please indicate using the options provided. In cases where more than one category may apply, select the category of the most disabling condition.

5

- ☐ No Is the client referred to intake / legal?
☐ No Is the client referred to intake / medical?
☐ No Is the client referred to intake / psych?

PRIMARY DRUG (check one only)

☐ Alcohol
☐ Amphetamines
☐ Barbiturates
☐ Cocaine
☐ Crack
☐ Hallucinogens
☐ Heroin/Opiates
☐ Inhalants
☐ Marijuana
☐ PCP
☐ Tranquilizers
☐ No drug use
☐ Other: _____

SECONDARY DRUG (check one only)

☐ Alcohol
☐ Amphetamines
☐ Barbiturates
☐ Cocaine
☐ Crack
☐ Hallucinogens
☐ Heroin/Opiates
☐ Inhalants
☐ Marijuana
☐ PCP
☐ Tranquilizers
☐ No drug use
☐ Other: _____

TERTIARY DRUG (check one only)

☐ Alcohol
☐ Amphetamines
☐ Barbiturates
☐ Cocaine
☐ Crack
☐ Hallucinogens
☐ Heroin/Opiates
☐ Inhalants
☐ Marijuana
☐ PCP
☐ Tranquilizers
☐ No drug use
☐ Other: _____

skip if no drug use

ROUTE (check one only)

☐ Injection
☐ Ingestion
☐ Nasal
☐ Smoking
☐ Other: _____

FREQUENCY OF USE
(check one only)

☐ Daily
☐ 1-3 per week
☐ 4+ per week
☐ Not in past month

Client's age when this drug
 was first used? _____

Average weekly dollar amount
 spent on this drug? \$ _____

Number of days since the
 client last used this drug? _____

skip if no secondary drug use

ROUTE (check one only)

☐ Injection
☐ Ingestion
☐ Nasal
☐ Smoking
☐ Other: _____

FREQUENCY OF USE
(check one only)

☐ Daily
☐ 1-3 per week
☐ 4+ per week
☐ Not in past month

Client's age when this drug
 was first used? _____

Average weekly dollar amount
 spent on this drug? \$ _____

Number of days since the
 client last used this drug? _____

skip if no tertiary drug use

ROUTE (check one only)

☐ Injection
☐ Ingestion
☐ Nasal
☐ Smoking
☐ Other: _____

FREQUENCY OF USE
(check one only)

☐ Daily
☐ 1-3 per week
☐ 4+ per week
☐ Not in past month

Client's age when this drug was
 first used? _____

Average weekly dollar amount
 spent on this drug? \$ _____

Number of days since the client
 last used this drug? _____

**STANCE
USE CONT.**

Number of days in the past year that the client used drugs: _____

Enter the date the client last used needles: _____

Enter the date the client last shared needles: _____

Enter the date the client last used a tobacco product: _____

Is the client currently receiving methadone treatment? _____

_____. / _____. / _____. (leave blank if N/A)

_____. / _____. / _____. (leave blank if N/A)

_____. / _____. / _____. (leave blank if N/A)

Yes ☐ No ☐

PSYCHIATRIC

Number of suicide attempts: _____

Number which were substance related: _____

Number resulting in hospitalization: _____

Most recent attempt: _____

Utilization history? ☐ Yes ☐ No

Number of instances of other violent behavior: _____

most recent: _____

Number of psychiatric hospitalizations: _____

most recent: _____

Client/past therapist name: _____ phone #: _____ - _____ - _____ release signed? ☐ Y ☐ N

6
REFERRED TO LEGAL: Indicate whether or not the client was referred to WH legal services at the time of admission.

REFERRED TO MEDICAL: Indicate whether or not the client was referred to WH medical services at the time of admission.

REFERRED TO PSYCH: Indicate whether or not the client was referred to WH psychiatric services at the time of admission.

DRUG: Select the Client's Primary Drug of choice. If 'No Drug Use' is selected, select the 'No Drug Use' option in the PRIMARY and TERTIARY Drug sections and skip directly to the METHADONE question.

METHOD: Select the category which best describes the most common method used by the Client to administer the Drug.

FREQUENCY OF USE: Select the category which best indicates the Frequency with which the Client used this Drug.

AGE OF FIRST USE: Please provide the Age of the Client the first time this Drug was used.

COST AMOUNT: Please provide the average weekly Dollar amount spent by the Client for this Drug within the past year.

MONTHS USED: Please enter the number of months since the Client last used this Drug.

SECONDARY DRUG: Please select the category which best describes the Client's Drug of Second Choice. If 'No Drug Use' is selected, indicate 'No Drug Use' in the TERTIARY DRUG section and skip directly to the METHADONE question.

METHOD: Select the category which best describes the most common method used by the Client to administer the Drug.

FREQUENCY OF USE: Select the category which best indicates the Frequency with which the Client used this Drug.

AGE OF FIRST USE: Please provide the Age of the Client the first time this Drug was used.

COST AMOUNT: Please provide the average weekly Dollar amount spent by the Client for this Drug within the past year.

MONTHS USED: Please enter the number of months since the Client last used this Drug.

THIRDARY DRUG: Please select the category which best describes the Third Drug of Choice for this Client. If 'No Drug Use', skip directly to the METHADONE question.

METHOD: Select the category which best describes the most common method used by the Client to administer the Drug.

FREQUENCY OF USE: Select the category which best indicates the Frequency with which the Client used this Drug.

AGE OF FIRST USE: Please provide the Age of the Client the first time this Drug was used.

COST AMOUNT: Please provide the average weekly Dollar amount spent by the Client for this Drug within the past year.

MONTHS USED: Please enter the number of months since the Client last used this Drug.

IN PAST YEAR: Indicate how many days, in the last year, the client used drugs.

NEEDLES: Indicate the date when the client last used needles. Leave blank if the client has never used needles.

SHARED NEEDLES: Indicate the date when the client last shared needles. Leave blank if the client has never shared needles.

TOBACCO USER: Indicate the date the client last used a tobacco product, whether it be cigarettes, snuff, chew, etc.

METHADONE: Indicate if the Client is currently receiving Methadone treatment.

SUICIDE ATTEMPTS: Indicate how many times the client has attempted suicide in the course of their own life.

SUICIDE ATTEMPTS RELATED: Indicate how many of the suicide attempts were substance related.

HOSPITALIZATIONS DURING IN HOSPITALIZATION: Indicate how many times the client was hospitalized due to a suicide attempt.

DATE OF MOST RECENT: Indicate the date of the most recent suicide attempt.

SUICIDE ATTEMPTS RELATED: Indicate whether or not the client has a history of self mutilation.

INSTIGATED VIOLENT BEHAVIOR: Indicate how many instances of violent behavior, not including suicide or self mutilation, the client has instigated.

DATE OF MOST RECENT: Indicate the date of the most recent act of violent behavior not including suicide attempts or self mutilation.

PSYCHIATRIC HOSPITALIZATIONS: Indicate how many times the client has been admitted to a psychiatric hospital.

DATE OF MOST RECENT: Indicate the date, of the most recent, when the client was admitted to a psychiatric hospital.

THERAPIST NAME: Indicate the name and phone number of the current, or past, therapist. YOU MUST check whether or not the client has given a release of the therapist name and phone number.

7

MedicationPhysical doctor name: _____ phone #: _____ - _____ - _____ release signed? ☐ Y ☐ N

	<u>Medication prescribed?</u>	<u>For what condition?</u>	<u>Taking as directed?</u>
Medication 1 -	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication 2 -	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication 3 -	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Use form MIS-006 if the client is taking more than 3 meds

☒ Yes ☐ No Does the client have allergies? If YES, what are they? _____

☒ Yes ☐ No Does the client have any history of seizures? How often? : _____ per ☐ Day ☐ Month ☐ Year ☐ Life

☒ Yes ☐ No Does the client have any history of loss of consciousness/head trauma/memory loss?

TUBERCULOSIS

☒ Yes ☐ No Within the past year, has the client been tested for tuberculosis?

If YES, enter date of the test: ____/____/____ result? ☐ Pos ☐ Neg

☒ Yes ☐ No enter the location of the test: _____

☒ Yes ☐ No has there been a follow up?

☒ Yes ☐ No is a follow up expected?

Is the client pregnant, enter the date the client became pregnant: ____/____/____

Is the client post partum (2 months post delivery), enter the date the pregnancy ended: ____/____/____

Enter the date the client last had unprotected or unsafe sex: (leave blank if N/A) ____/____/____

☒ Yes ☐ No Is the client receiving Medi-Cal benefits?

☐ No If NO, is the client pending to receive Medi-Cal?

Enter the number of emergency room visits within the past one year: _____

Enter the number of days in the past year the client was hospitalized: _____

Axis IVDiagnosisCode

AXIS I-a:	_____	_____
AXIS I-b:	_____	_____
AXIS I-c:	_____	_____
AXIS II:	_____	_____
AXIS III-a:	_____	_____
AXIS III-b:	_____	_____
AXIS III-c:	_____	_____
AXIS IV:	_____	_____

AXIS V(GAF): _____

☐ Yes ☐ No Has this client been identified as a dual diagnosed client by a mental health professional?**TREATMENT RECOMMENDATION****NOTES / COMMENTS**

Intake Counselor^R: _____ <small>(Print intake counselor's name)</small> <small>(Counselor's signature)</small>	Supervisor^R: _____ <small>(Print counselor's supervisor's name)</small> <small>(Counselor's supervisor's signature)</small>	Therapist^R: _____ <small>(Print intake therapist's name)</small> <small>(Intake therapist's signature)</small>
--	---	--

Intake Signed^R: ____/____/____	Date Signed^R: ____/____/____	Date Signed^R: ____/____/____
--	--	--

DOCTOR: Indicate the name and phone number of the client's medical doctor. YOU MUST check whether or not the client has a release of the doctor's name and phone number.

CATION: For each medication prescribed to the client, provide the name of the medication, what the medication was prescribed for, whether or not the client is taking the medication as prescribed. This pertains to current medication only, not medication prescribed in the client's life. If more than 3 medications are prescribed to the client use the MIS-006 form. **ALLERGIES:** Indicate whether or not the client is allergic to anything. If the client does have allergies, list each one.

RES: Indicate if the client has ever had a seizure. If so, indicate how often the client has seizures.

OF CONSCIOUSNESS: Indicate whether or not the client has ever lost consciousness, has had head trauma, or memory loss.

RCULOSIS: Indicate if the Client has been tested, within the past year for Tuberculosis. If the Client was tested, enter the date of testing, the results of the test, the location of the test, whether or not there was a follow-up, and whether or not there will be a follow up.

NANT: If the client is pregnant at the time of admission, indicate the date the client became pregnant.

PARTUM: If the client has had a child in the last two (2) months, indicate the date of the birth.

FE SEX: Indicate if, within the past year, the Client has had unprotected or unsafe sexual activity.

Cal BENEFITS: Indicate if the Client is currently receiving MEDICAL benefits.

Cal PENDING: Indicate if the Client has applied to receive MEDICAL benefits and is currently waiting for approval or disapproval.

AGENCY ROOM VISITS: Enter the total number of times, within the past year, that the Client has used Emergency Room services.

AR HOSPITALIZATIONS: Indicate how many days in the last year the client was hospitalized.

GNOSIS: Indicate the diagnosis for the Axis I-a, Axis I-b, Axis I-c, Axis II, Axis III-a, Axis III-b, ~~Axis III-c~~ and Axis IV.

CODE: Indicate the diagnosis code for the Axis I-a, Axis I-b, Axis I-c, Axis II, Axis III-a, Axis III-b, Axis III-c, and Axis V.

DIAGNOSE: Check 'Yes' if in addition to a substance related disorder the client has been diagnosed with a psychiatric disorder. Note this is to be determined by a therapist, psychiatrist, or psychologist, but does not have to be a Walden House staff member.

TMENT RECOMMENDATION: Indicate the treatment recommendation.

MENTS: Use this section for any Notations or Comments appropriate to this Admission.

SELOR'S NAME: Please print the Name of the Intake Counselor.

SELOR'S SUPERVISOR'S NAME: Please print the Name of the Intake Counselor's Supervisor.

APIST'S NAME: Please print the Name of the Intake Therapist.

APIST'S SIGNATURE: Please sign the form after reviewing all data for accuracy.

SELOR'S SIGNATURE: Please sign the form after reviewing all data for accuracy.

RVISOR'S SIGNATURE: Please sign the form after reviewing the Counselor's work for accuracy.

THERAPIST SIGNED: Please indicate the date the therapist signed the form.

COUNSELOR SIGNED: Please indicate the date the counselor signed the form.

PERVISOR SIGNED: Please indicate the date the supervisor signed the form.

WALDEN HOUSE INC - STAFF REPORT

WH FACILITY DEPARTURE FORM

Date Information is Gathered^R: ____/____/____

Client Name^R: ____ WH ID^R: ____ Date of Birth^R: ____/____/____
First Middle Last

at phase of Tx was the client in at the time of discharge?

(note - only check "NA" if the client was in Detox, 45 day WITS, 45 day MDSP, Drug Court Day Treatment, Aftercare, or any Out Patient component)

Orientation ☐ TC ☐ Pre-ReEntry ☐ ReEntry ☐ N/A

IS DISCHARGE INVOLVED: (check all that apply)

- ☐ change of funding
☐ change of facility
☐ drug use
☐ drug use w/shared needles
☐ criminal activity
☐ client was arrested
☐ violence
☐ threat of violence
☐ client was incarcerated at the time of discharge
☐ client's Parole/Probation Officer has been notified
☐ client's parole/probation was violated or revoked
☐ sexual activity that violates program norms
☐ flirting with other client(s)
☐ failure to display sincerity/motivation
☐ lying
☐ breaking confidentiality
☐ the client was pulled to another institution by the criminal justice system
☐ the client is excluded from incarcerated Tx by the criminal justice system

EDUCATION (check one only)

- ☐ 3rd grade or less ☐ 4th grade
☐ 5th grade ☐ 6th grade
☐ 7th grade ☐ 8th grade
☐ 9th grade ☐ 10th grade
☐ 11th grade ☐ 12th grade
☐ College Fresh ☐ College Soph
☐ College Jr ☐ College Sr
☐ Post graduate ☐ IEP

(Yes has to be checked for one of the following six options)

- es ☐ No Did the client complete treatment?
 es ☐ No Has this client abandoned treatment/AMA (Against Medical Advice)?
 es ☐ No Was the client asked to leave for violating program norms?
 es ☐ No Was the client discharged due to or because of psychiatric symptoms?
 es ☐ No Was the discharge influenced by financial/monetary interests?
 es ☐ No Is the client deceased?
 es ☐ No Did the client participate in the Parenting class? (check all that apply)
 es ☐ No Did the client participate in Parenting groups?
 es ☐ No Has the client reunified with children previously NOT in the client's custody?
 es ☐ No Has this client been referred to additional Tx (including within WH)?
 If so, which where? _____
 es ☐ No Is it a higher level of treatment than what the client is coming from?
 es ☐ No Has this client been admitted to additional Tx (including within WH)?
 If so, which where? _____
 es ☐ No Is it a higher level of treatment than what the client is coming from?
 es ☐ No Will this client Leave with the Graces of the House?
 es ☐ No Will this client participate in Walden House Graduation?
 es ☐ No Is this Client prohibited from re-admission to Walden House?
 Enter the date the client last used a tobacco product: ____/____/____ (leave blank if N/A)

CERTIFICATIONS (check one only)

- ☐ GED
☐ HS diploma
☐ Two year degree
☐ Four year degree
☐ Post grad

☐ Other: _____

Date the highest educational level was completed ____/____/____

EMPLOYMENT (check one only)

- ☐ emp & student ☐ Unemp/disabled
☐ student ☐ Unemp/no seek
☐ full time emp ☐ Unemp/seeking
☐ emp & student ☐ Volunteer
☐ part time emp
 how long: Enter salary: _____
☐ Days ☐ Week
☐ Months _____ per ☐ Month
☐ Years _____ ☐ Year

LIVING SITUATION (check one only)

- ☐ Spouse/Partner ☐ Homeless
☐ Public housing ☐ Relatives
☐ Share/No pay ☐ Foster care
☐ Sober Living Environ. ☐ Share/Pay ex
☐ Mntl hlth institution ☐ Incarcerated
☐ Transitional Tx prog ☐ Independent
☐ Residential Tx prog ☐ Parent/Guard
☐ Women & Children's Tx prog
 How long? _____
☐ Days
☐ Months
☐ Years

JUSTICE SYSTEM (check one only)

- ☐ Not applicable
☐ Diversion
☐ Incarcerated/Pending sentence
☐ Incarc/sentence
☐ Incarc/Indeterminate sentence
☐ Pending sentence
☐ Parole
☐ Probation
☐ Supervised Release

You may skip this section if the client has no children under the age of 18 — Use form MIS-006 if client has more than 3 children

CHILDREN/DEPENDENTS	Child's first name?	Child's gender	Child's date of birth	CPS court order?	Who does the child live with? (check one only)
11 -	_____	<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Client <input type="checkbox"/> Relatives <input type="checkbox"/> Friend <input type="checkbox"/> Foster care <input type="checkbox"/> Unknown <input type="checkbox"/> Other
12 -	_____	<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Client <input type="checkbox"/> Relatives <input type="checkbox"/> Friend <input type="checkbox"/> Foster care <input type="checkbox"/> Unknown <input type="checkbox"/> Other
13 -	_____	<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Client <input type="checkbox"/> Relatives <input type="checkbox"/> Friend <input type="checkbox"/> Foster care <input type="checkbox"/> Unknown <input type="checkbox"/> Other

ICATION Medical doctor name: _____ phone #: _____ release signed? ☐ Y ☐ N
Medication prescribed? For what condition? Taking as directed?

Medication 1 - _____ ☐ Yes ☐ No
 Medication 2 - _____ ☐ Yes ☐ No
 Medication 3 - _____ ☐ Yes ☐ No

Use form MIS-006 if the client is taking more than 3 meds

CLIENT RATINGS	The client rates:	poor	fair	good	excellent
(blank if client available)	overall life satisfaction as:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	physical health as:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
	mental health as:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Depression Inventory score _____	their ability to abstain from drugs/alcohol as:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

IV	Diagnosis	Code
AXIS I-a:	_____	_____
AXIS I-b:	_____	_____
AXIS I-c:	_____	_____
AXIS II:	_____	_____
AXIS III-a:	_____	_____
AXIS III-b:	_____	_____
AXIS III-c:	_____	_____
AXIS IV:	_____	_____

AXIS V(GAF): _____

☐ Yes ☐ No Has this client been identified as a dual diagnosed client by a mental health professional?

CLIENT FORWARDING ADDRESS

CONTACT PERSON

SS: _____	Name: _____
_____	Address: _____
_____	City: _____
_____ Zip Code: _____	State: _____ Zip Code: _____
_____	Relation: _____ <input type="checkbox"/> Newsletter
_____ - _____ - _____ (Client Initials)	Phone: _____ - _____ - _____

SUMMARY INFORMATION

1. Briefly summarize the reason for discharge: _____

2. What were stated outcomes and expectations established in the client's treatment plan? _____

3. What established treatment plan outcomes and expectations were achieved by the client? _____

4. Briefly summarize the client's overall treatment episode: _____

5. Describe client's vocational/educational achievements: _____

6. What are the client's strengths and abilities at time of discharge? _____

7. What are the client's assessed needs at time of discharge? _____

8. What is the client's preferred discharge/follow-up plan? _____

**DISCHARGE
COUNSELOR:**

(Print discharge counselor's name)

(Counselor's signature)

**DISCHARGE
SUPERVISOR:**

(Print counselor's supervisor's name)

(Counselor's supervisor's signature)

**DISCHARGE
THERAPIST:**

(Print discharge therapist's name)

(Discharge therapist's signature)

DATE SIGNED:**DATE SIGNED:****DATE SIGNED:**